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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE

For all Vermont hospitals payment for inpatient general hospital care will be made at per diem rates established for each hospital based on reasonable cost. Out-of-state hospitals, including border hospitals, will be paid based on rates established by the out-of-state Medicaid agency. Payments made pursuant to these limitations will be deemed to be payment in full for services rendered and the hospitals may not bill, or otherwise collect from, the recipient or anyone acting on his behalf any supplemental amount.

For Medicaid recipients with joint Medicare eligiblity payment is made to providers in an amount determined by Medicare to cover coinsurance and deductible amounts remaining after Medicare payment.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE

General Hospitals

Effective for services provided on or after February 1, 1993, the Vermont Medicaid Program will reimburse all general hospitals at prospective per diem rates.

- **Participating General Hospitals**

  All Vermont general hospitals and out-of-state general hospitals receiving Medicaid payments during state fiscal year 1992 of $100,000 or more will be defined as "participating" hospitals.

  To establish the prospective rates, base year costs reported by participating hospitals were identified. Categories of cost included in the ratesetting methodology are those related to routine services (including malpractice costs and medically necessary private room costs), ancillary services, capital, and direct medical education. The initial base year is the participating hospitals' 1989 fiscal year. Rates will be rebased periodically.

  Implementation year rates have been established by inflating base-year costs using the percent of change in the moving average of the Data Resources, Inc./McGraw Hill Health Care Cost HCFA-Type Hospital Market Basket Index from the mid-point of each participating hospital's base cost reporting year to the mid-point in state fiscal year 1993. Future annual rate increases will be based on published inflation index changes.

  The prospective rates are set by peer group and by accommodation type. Three peer groupings have been established for the reimbursement system. The peer groups are:

  - Teaching hospitals
  - Non-teaching hospitals with 80 beds or more
  - Non-teaching hospitals with fewer than 80 beds

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE (CONTINUED)

Teaching hospital status and bed size have been determined based on information published by the American Hospital Association. In the absence of information substantiating the teaching status of a hospital, it will be paid at the respective non-teaching peer group rate by accommodation type. Peer group composition will not change until rates are rebased.

Reimbursement rates have been established for four accommodation types (medical/surgical, nursery, intensive care unit, other intensive care unit). A fifth accommodation type has been established for participating hospitals specifically designated by the Commissioner of the Vermont Department of Mental Health and Mental Retardation to provide intensive psychiatric care to mentally ill patients.

After appropriate inflation adjustments from the base year, rates by accommodation type will be set at the lower of:

1. Peer group median cost

2. The sum of hospital-specific cost per day plus an incentive-type payment computed as 50 percent of the difference between:

   - the peer group median cost per day, and

   - the sum of hospital-specific cost per day

3. A fixed percentage increase over the 1992 Vermont Medicaid rate of 12 percent.

To encourage greater cost efficiency and the above methodology notwithstanding, payments to out-of-state teaching hospitals cannot exceed Vermont teaching hospital calculated rates.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE (CONTINUED)

- **Non-participating General Hospitals**

  Hospitals not defined as "participating" are reimbursed by accommodation type at the median rate established for the peer group in which the hospital would be classified if it were a participating hospital.

  The methodology described above does not preclude the Program from reimbursing at negotiated rates non-participating hospitals providing unusual and highly complex services (such as transplants) that are not available in participating hospitals or in designated border hospitals.

For Medicaid recipients with joint Medicare eligibility, payment is made to providers in an amount determined by Medicare to cover coinsurance and deductible amounts remaining after Medicare payment.

Payments made pursuant to these methods and standards will be deemed to be payment in full for services provided and the hospitals may not bill, or otherwise collect from, the recipient or anyone acting on his/her behalf any supplemental amount.

Inappropriate level of care days are reimbursed at a per diem rate established by the Division of Rate Setting, to be in effect for care provided during each successive State fiscal year, with no retroactive adjustments. The reimbursement rate is equal to the average statewide rate per patient day paid for services furnished in nursing facilities during the previous calendar year.

Inpatient Psychiatric Facility Services - State Institutions

Reimbursement will be made at per diem rates established for the Vermont State Hospital based on reasonable costs. Interim rates are established by the Department of Mental Health and adjusted at year end.

Inpatient Psychiatric Facility Services - Non-public Facilities

For services provided to individuals under age 22 at the Brattleboro Retreat, reimbursement will be established by the Department of Mental Health at the average of rates paid to all non-participating general hospitals for the medical/surgical type accommodation. Payment rates will be prospective with no retroactive adjustments.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE (CONTINUED)

Inpatient Psychiatric Facility Services – Non-public Facilities

For services provided to individuals under age 22 at the Brattleboro Retreat under the Department of Developmental and Mental Health Services' (DDMHS) funding source, the Commissioner of DDMHS shall establish (through negotiation) an all-inclusive, prospective, per diem rate.

For services provided to individuals at the Brattleboro Retreat age 65 or older, the all inclusive per diem rate shall be the median rate paid to participating, non-teaching, general hospitals with over 80 beds and increased annually based on published inflation index changes.

For services provided to individuals ages 22 to 64 at the Brattleboro Retreat under the Vermont Health Access Plan Section 1115 waiver (project # 11-W-00051/1), the all inclusive per diem rate shall be the same as that set for individuals age 65 and older.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE (CONTINUED)

A Payment Adjustment for Hospitals Qualifying as Disproportionate Share Hospitals

A disproportionate share hospital is a hospital (a) which has a Medicaid inpatient utilization rate (as defined in §1923 of the Act) that is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or (b) which has a low-income utilization rate (as defined in §1923 of the Act) exceeding 25 percent. Calculations are based on the state's most current data base and updated yearly. Additionally, the hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state Medicaid plan. The term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The above obstetric-related criteria do not apply to hospitals in which the inpatients are predominately individuals under 18 years of age, or to hospitals which did not offer non-emergency obstetric services as of December 21, 1987. No hospital may qualify as a disproportionate share hospital unless it has a Medicaid inpatient utilization rate of not less than one percent.

The payment adjustment is calculated as an amount equal to the product of the hospital's Medicaid operating cost payment (the per diem rate) times the hospitals' Medicare disproportionate share adjustment percentage developed under rules established under §1886 (d)(5)(F)(iv) of the Act, that can be paid to eligible hospitals.

Supplementary Disproportionate Share Payments to General Hospitals

Effective for payments made after July 1, 1998, a Vermont general hospital not otherwise qualifying for disproportionate share payments, which meets the requirements of §1923(d) of the Social Security Act and which has a Medicaid inpatient utilization rate of not less than one percent shall qualify for supplementary disproportionate share payments.

General hospitals eligible for supplemental payments shall be paid as follows:

Each year of the program the Commissioner of Social Welfare shall determine the amount of funds to be distributed among qualifying hospitals.

The funds shall be distributed to each qualifying hospital according to its proportion to the total funds available for the year. The proportions shall be calculated by dividing the cost of each hospital's uncompensated care (bad debt and free care) by the total cost of uncompensated care for all qualifying hospitals.

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE (CONTINUED)

Supplementary Disproportionate Share Payments to General Hospitals (Continued)

Only in the state fiscal year 1998, an adjustment to the state fiscal year 1998 payment will be paid to all qualifying hospitals which shall be the difference between payments made using a distribution method based on each hospital's proportion of the cost of free care, plus ½ of bad debt, plus the Medicaid contractual allowance and a distribution method based on each hospital's proportion of the cost of free care plus bad debt.

Supplemental payments made by the Medicaid program under this provision are deemed to be applied first to the costs of services to Medicaid recipients, and then to uninsured patients.

In the event that any payment is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Commissioner shall readjust the payments to hospitals as necessary to qualify for FFP.

A Payment Adjustment May Also Be Made for a State-Owned Hospital Qualifying As a Disproportionate Share Hospital

A disproportionate share state-owned hospital is a hospital owned and operated by the State of Vermont that has an inpatient Medicaid utilization rate of not less than one percent of its fiscal year 1994.

The obstetric-related criteria cited on page 1d do not apply to hospitals in which the inpatients are predominately individuals under age 18, or to hospitals which did not offer non-emergency services as of December 21, 1987.

State-owned hospitals which meet the above criteria will receive a payment adjustment equal to 100 percent of the cost of providing services to Medicaid patients, less the amount paid under non-disproportionate share payment provisions, and to uninsured patients, less payments made. Cost and patient data will be based on the most recently completed fiscal year. Cost and/or payor mix data willl be from hospital records and will be subject to full audit by state and federal fiscal intermediaries. This methodology will assure that the payment adjustment is reasonably related to the costs, volume and proportion of services provided to patients eligible for medical assistance under the State Plan approved under Title XIX or to low-income patients. This payment adjustment is in lieu of the disproportionate share hospital payment adjustment on page 1d of the State Plan.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE (CONTINUED)

Pediatric Outlier Adjustment for Services Involving Exceptionally High Costs

An annual outlier payment adjustment will be made to any hospital that incurred exceptionally high cost for medically necessary inpatient services furnished to infants under one year of age and to any disproportionate share hospital that incurred exceptionally high cost for such services furnished to children under age six.

Using the most recent state fiscal year Medicaid data, the following eligibility thresholds will be calculated for payment:

Exceptionally High Cost

Exceptionally high cost is defined and determined as follows:

(1) Calculate the mean of each hospital's Medicaid inpatient claim billed amounts;

(2) Calculate the standard deviation for each hospital's Medicaid inpatient claim billed amounts; and

(3) Multiply each hospital's standard deviation by four; and add the result to the hospital's mean Medicaid inpatient claim billed amount to determine the Medicaid threshold.

Determining Eligibility for an Outlier Adjustment

For each hospital, the following calculation shall be performed to determine individual hospital eligibility, whether for patients under six years or under one year:

Compare the Medicaid inpatient claim billed amount for each patient to the hospital-specific "high cost" threshold. If the billed amount exceeds the hospital's threshold, the hospital is eligible for an outlier adjustment.

Outlier Adjustment Payment

The outlier adjustment payment for each eligible hospital will be one half of the hospital's specific per diem rate.

Enclosure 3

Attachment 4.19 A

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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